This form may be completed online, printed and mailed to the address listed below.

Documentation of Course Completion

This is to certify that

_____

(Name)

_____

(Social Security #)

has successfully completed the

☐ **40 hour** ☐ **Additional 20 hour**

(Check the appropriate length of course)

for Medication Aide

on

_____

(Date of Course Completion)

I/We

_____

(Name/ Signature of Person and Entity)

have provided this course and have determined successful completion of the course for the person indicated above.

Department of Health & Human Services
Regulation and Licensure
Credentialing Division
PO Box 94986
Lincoln NE 68509-4986

3/03